

This chapter implements STANAG 2068 Med.

CHAPTER 1

HOSPITALIZATION SYSTEM IN A THEATER OF OPERATIONS

1-1. Combat Health Support in a Theater of Operations

a. A theater of operations (TO) is that portion of an area of war necessary for military operations and for the administration of such operations. The scenario depicts the size of the TO and the US Forces to be deployed. The theater is normally divided into a combat zone (CZ) and a communications zone (COMMZ). In some instances, the COMMZ may be outside the TO and located in offshore support facilities, Third Country support bases, or in the continental United States (CONUS). The CZ begins at the Army/corps rear boundary and extends forward to the extent of the commander's area of influence. The COMMZ begins at the corps rear boundary and extends rearward to include the area(s) needed to provide support to the forces in the CZ.

b. The mission of the AMEDD is to conserve the fighting strength. This mission of CHS is a continuous and an integrated function throughout the TO. It extends from the CZ back through the COMMZ and ends in CONUS. Combat health support maximizes the system's ability to maintain presence with the supported soldier, return injured, sick, and wounded soldiers to duty, and to clear the battlefield of soldiers who cannot return to duty (RTD). Patients are examined, treated, and identified as RTD or nonreturn to duty (NRTD) as far forward as is medically possible. Early identification is performed by the treating primary care provider and continues in the evacuation chain with constant reassessment. Patients requiring evacuation out of the division who are expected to RTD within

the theater evacuation policy are evacuated to a corps and/or COMMZ hospital. Those patients classified as NRTD follow the evacuation chain for trauma care and stabilization for evacuation out of the theater.

1-2. Echelons of Combat Health Support

The CHS system within a TO is organized into four echelons of support which extend rearward throughout the theater (see Figure 1-1). The system is tailored and phased to enhance patient identification, evacuation, treatment, and RTD as far forward as the tactical situation will permit. Hospital resources will be employed on an area basis to provide the utmost benefit to the maximum number of personnel in the area of operations (AO). Each echelon reflects an increase in capability, with the function of each lower echelon being contained within the capabilities of the higher echelon. Wounded, sick, or injured soldiers will normally be treated, returned to duty, and/or evacuated to CONUS (Echelon V) through these four echelons:

a. Echelon 1. This echelon is also known as unit level. Care is provided by designated individuals or elements organic to combat and combat support (CS) units and elements of the area support medical battalion (ASMB). Major emphasis is placed on those measures necessary to stabilize the patient (maintain airway, stop bleeding, prevent shock) and allow for evacuation to the next echelon of care.

(1) *Combat medic.* This is the first individual in the CHS chain who makes medically

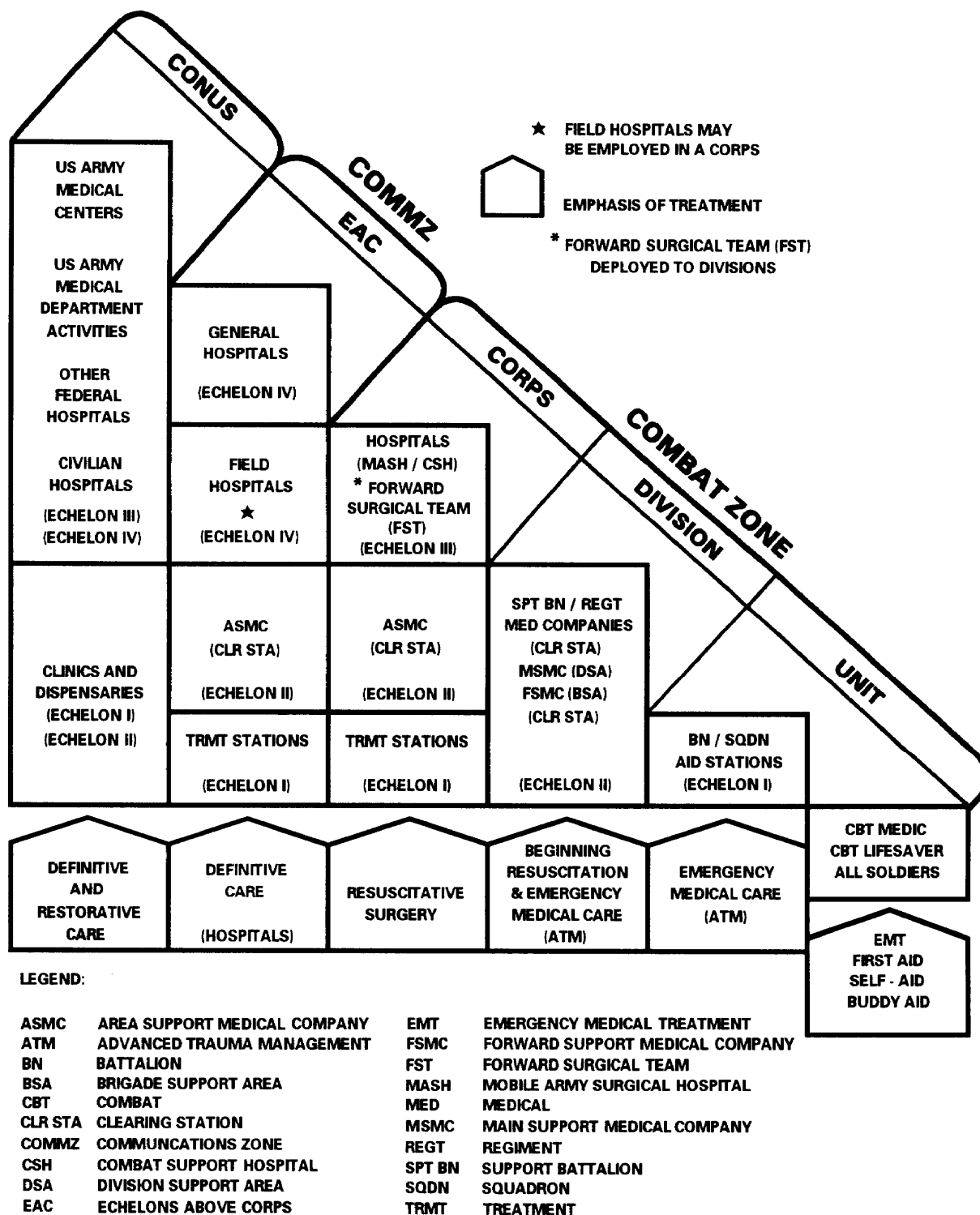


Figure 1-1. Echelons of combat health support.

substantiated decisions based on medical military occupational specialty (MOS)-specific training. The combat medic is supported by first-aid providers in the form of self-aid and buddy aid and the combat lifesaver.

(a) Self-aid and buddy aid.

The individual soldier is trained to be proficient in a variety of specific first-aid procedures with particular emphasis on lifesaving tasks. This training enables the soldier, or a buddy, to apply immediate care to alleviate a life-threatening situation.

(b) Combat lifesaver.

Enhanced medical training is provided to selected individuals who are called combat lifesavers. These individuals are nonmedical unit members selected by their commander for additional training to be proficient in a variety of first-aid procedures. A minimum of one individual per squad, crew, team, or equivalent-sized unit is trained. All combat units and some CS and combat service support (CSS) units have combat lifesavers. The primary duty of these individuals does not change. The additional duties of combat lifesavers are performed when the tactical situation permits. These individuals provide enhanced first-aid care for injuries prior to treatment by the combat medic. The training is normally provided by medical personnel assigned or attached to the unit. The training program is managed by a senior medical person designated by the commander.

(2) Treatment squad. The treatment squad consists of a field surgeon, a physician assistant (PA), two noncommissioned officers (NCOs), and four medical specialists. The personnel are trained and equipped to provide advanced trauma management (ATM) to the battlefield casualty. Advanced trauma management is emergency care designed to resuscitate and stabilize the patient for

evacuation to the next echelon of care. Each squad can split into two trauma treatment teams. These squads are organic to medical platoons/sections in maneuver battalions and designated CS units and medical companies of separate brigades, divisions, and echelons above division in the ASMB. Treatment squads (treatment teams) may be employed anywhere on the battlefield. When not engaged in ATM, these elements provide routine sick call services on an area basis. Echelon I care for units not having organic Echelon I capability is provided on an area basis by the organization responsible in the sector.

b. Echelon II. This echelon may also be known as division level. Care at this echelon is rendered at the clearing station (division or corps). Here the casualty is examined and his wounds and general status are evaluated to determine his treatment and evacuation precedences, as a single casualty among other casualties. Those patients who can RTD within 1 to 3 days are held for treatment. Emergency medical treatment (EMT) (including beginning resuscitation) is continued and, if necessary, additional emergency measures are instituted; but they do not go beyond the measures dictated by the immediate necessities. The division clearing station has blood replacement capability, limited x-ray and ambulatory services, patient holding capability, and emergency dental care. Clearing stations provide Echelon I CHS functions on an area basis to those units without organic medical elements. Echelon II CHS also includes preventive medicine (PVNTMED) activities and combat stress control (CSC). These functions are performed typically by company-sized medical units organic to brigades, divisions, and ASMBs.

c. Echelon III. The first hospital facilities are located at this echelon. Within the CZ, the mobile army surgical hospital (MASH) and the CSH are staffed and equipped to provide

resuscitation, initial wound surgery, and post-operative treatment. Although the MASH is an Echelon III facility, it is designed to be employed within the division area. At the CSH, patients are stabilized for continued evacuation, or returned to duty. Those patients who are expected to RTD within the theater evacuation policy are regulated to a facility that has the capability for reconditioning and rehabilitating.

d. Echelon IV. At this echelon, the patient may be treated at the general hospital (GH) or the field hospital (FH). The GHs are staffed and equipped for general and specialized medical and surgical care. Those patients not expected to RTD within the theater evacuation policy are stabilized and evacuated to CONUS. At the FH, reconditioning and rehabilitating services are provided for those patients who will be RTD within the theater evacuation policy.

e. Echelon V. This echelon of care is provided in CONUS. Hospitalization is provided by DOD hospitals (military hospitals of the triservices) and Department of Veterans Affairs (DVA) hospitals. Under the National Disaster Medical System, patients overflowing DOD and DVA hospitals will be cared for in designated civilian hospitals.

1-3. Theater Hospital System

a. Medical Force 2000 is the modernization effort to restructure the CHS system including hospitalization in support of a TO. This system consists of four hospitals, a medical company, holding, and six medical/surgical teams. The two corps hospitals are the MASH and the CSH. The two COMMZ hospitals are the FH and the GH. In addition to these hospitals, the medical company, holding, provides a 1,200-cot convalescent capability. For a detailed discussion

on the Medical Force 2000 hospital system, refer to FM 8-10.

(1) *Mobile army surgical hospital.* This hospital is a 30-bed facility with the primary mission of providing lifesaving surgical and medical care to stabilize patients for further evacuation, either to the CSH or to COMMZ hospitals. Patients are held approximately 24 to 36 hours until considered stable enough to tolerate a bed-to-bed transfer without incurring further risk to their condition. The MASH will be employed in the corps area or forward in the division rear area. This hospital is not Deployable Medical Systems (DEPMEDS)-equipped. It is 100 percent mobile with organic vehicles.

(2) *Forward surgical team.* A forward surgical team (FST) will replace the two surgical squads in each of the following: the airborne division; the air assault division; and the 2d Armored Cavalry Regiment (ACR). The FSTs will also replace the medical detachment (surgical) and the 30-bed MASH. This team will be a corps augmentation for divisional and nondivisional medical companies. It will provide emergency/urgent initial surgery and nursing care after surgery for the critically wounded/injured patient until sufficiently stable for evacuation to a theater hospital. The FSTs not organic to divisions and the 2d ACR will be assigned to a medical brigade or group and normally attached to a corps hospital when not operationally employed and further attached for support to a divisional/nondivisional medical company.

(3) *Combat support hospital.* This hospital is addressed in detail in the following chapters of this publication.

(4) *Field hospital.* This hospital is a 504-bed facility with the mission of providing hospitalization for patients and for reconditioning and rehabilitating those patients who can RTD

within the theater evacuation policy. The majority of patients within this facility will be in the convalescent care category. The FH is normally located in the COMMZ, but could be used in the corps rear when geographical operational constraints dictate. It is 20 percent mobile with organic vehicles.

(5) *General hospital.* This organization is a 476-bed facility with the mission of providing stabilization and hospitalization for patients who require either further evacuation out of the TO, or who can RTD within the theater evacuation policy. The GH will normally be located in the COMMZ. Its mobility is 10 percent with organic vehicles.

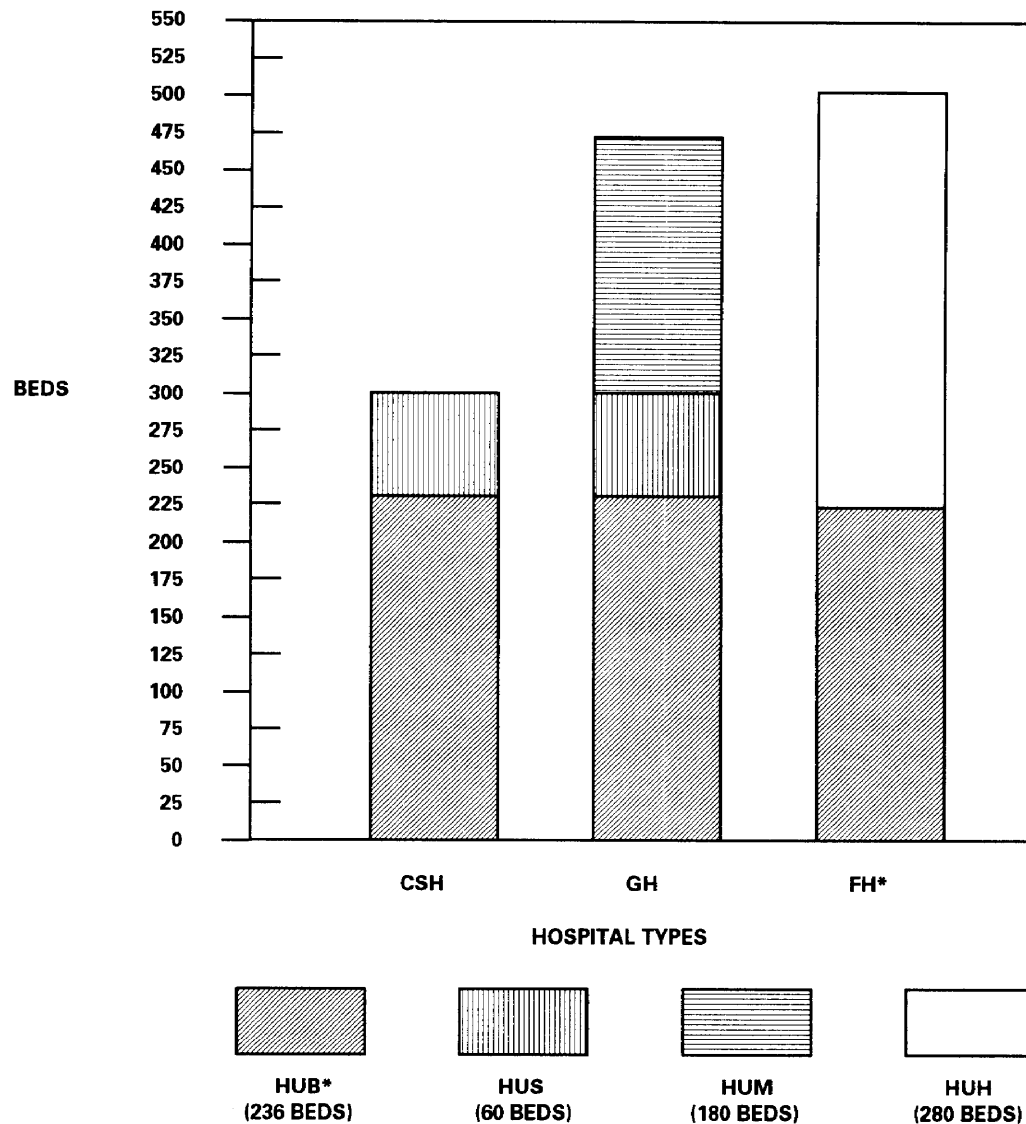
(6) *Medical company, holding.* This unit provides reconditioning and rehabilitation for up to 1,200 convalescent care patients. This unit may be located in the corps or COMMZ. It is used to augment the CSH when operational necessity dictates. It may also be used in the

3-week CSC reconditioning program. This unit is staffed and equipped to provide care for minimal category (self-care) patients.

b. The CSH, FH, and GH are designed using the following four modules:

- (1) Hospital unit, base (HUB).
- (2) Hospital unit, surgical (HUS).
- (3) Hospital unit, medical (HUM).
- (4) Hospital unit, holding (HUH).

They are configured using the appropriate combination of these modules. The HUB can operate independently, is clinically similar, and is located in each hospital as the initial building block. The other three mission-adaptive modules (HUS, HUM, and HUH) are dependent upon the HUB (see Figure 1-2, page 1-6).



* ALTHOUGH THE HUB HAS 236 BEDS, WHEN IT IS USED AS THE BASE COMPONENT FOR THE FH, IT IS ONLY STAFFED TO PROVIDE HOSPITALIZATION FOR 224 PATIENTS. IN THE FH CONFIGURATION, THE HUB HAS TWO INTENSIVE CARE WARDS THAT PROVIDE CARE FOR UP TO 24 PATIENTS. BY CONTRAST, IN THE CSH AND GH CONFIGURATIONS, THE HUB HAS THREE INTENSIVE CARE WARDS THAT PROVIDE CARE FOR UP TO 36 PATIENTS. THIS IS THE REASON FOR THE 12-PATIENT DIFFERENCE IN THE FH CONFIGURATION.